Dan K. Dube, D.M.D.
5653 Carolina Beach Dr., Suite C1
Wilmington, NC 28412
Phone: (910)791-0986
Fax: (910)791-2902

Consent from Patient for Release of Dental Information & Records

Instructions:
Please complete this form and mail or fax back to us.

I hereby authorize you to send a copy of the dental records, including all progress notes and radiographs for: _____ (Patient's name)**

from the office of: Daniel K. Dube, DDS, PA to: (new dentist name & address)

_____

_____

_____

I release you from all legal responsibility or liability that may arise from this authorization.

Thank you.

_____ _____

Signature of Patient, Parent or Legal Guardian Date

**If multiple records are wanted please fill out separate form for each.